

Case Management Assurance

Student Information

Name: John Doe Date of Birth (mm/dd/yy) 2/1/98

Diagnostic Code: 315

Provider Information

Provider Name: James Hill Name of School: Vermont Elementary School

Supervisory Union Name : Vermont Supervisory Union

IEP Services Provided

Enter below the initiation date of the student's IEP and the number of hours per week listed on that IEP for Case Management Services:

IEP Initiation/Amendment Date	IEP Hours Per Week (indicate if service is monthly)
9/15/2008	1
9/15/08 (amended 10/6/08)	1hr per month

Billing Period Assurance

This assurance covers the following dates for the billing period:

From:	10/1/08
To:	10/31/08

I assure that I provided the following number of hours of case management during this billing period.

2 Hours

Provider Signature: _____ **Date:** _____